

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Registration District No. 384

Primary Registration District No. 5339

Registrar's No.

1. PLACE OF DEATH:  
(a) County Hawell  
(b) City or town Rural - Spring Creek  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)  
In this community 75 years  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State MO (b) County Hawell  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Mathews  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME SOPHRONIA ROBERSON  
3. (b) If veteran, name war \_\_\_\_\_  
3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Nov day 6  
year 1940 hour 6 minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from Nov 6  
1940 to Nov 6 1940  
that I last saw her alive on Nov 6 1940  
and that death occurred on the date and hour stated above.

4. Sex Fe 5. Color or race W  
6. (a) Single, widow, married, divorced Widowed  
(b) Name of husband or wife David Roberson  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Jan 26 1863  
(Month) (Day) (Year)

Immediate cause of death Bronchial Pneumonia  
Duration 10 days

8. AGE: Years 77 Months 9 Days 11  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to 10 1/2  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

9. Birthplace Hawell County MO  
(City, town, or county) (State or foreign country)  
10. Usual occupation House Wife  
11. Industry or business \_\_\_\_\_  
12. Name Sam Wilson \_\_\_\_\_  
13. Birthplace Unknown \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name Unknown \_\_\_\_\_  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature C. W. Roberson  
(b) Address Mathews, MO  
17. (a) Burial (b) Date thereof 11-7-40  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Cure all, MO  
18. (a) Signature of funeral director O. B. McClure  
(b) Address Wainessville MO  
19. (a) 11-7-40 (b) Uida W. SIMONS  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
344 (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
23. Signature J. R. Beach (M. D. or other) Solo  
Address Edyah MO Date signed \_\_\_\_\_

**RECEIVED**

District Health Officer No. 5.

District File Number 12401115

Date Filed \_\_\_\_\_

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**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**